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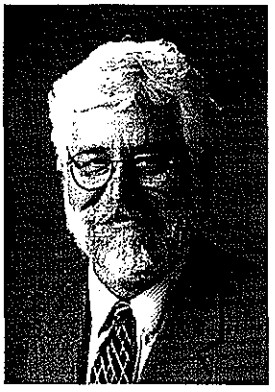
INCLUDING SPIRITUALITY

Larry Decker, Ph.D.



Larry Decker, Ph.D.

Any attempt to combine spirituality with psychotherapy must make a distinction between spirituality and religion. For the purpose of this article spirituality is seen as our search for purpose and meaning involving both transcendence (the experience of existence beyond the physical/psychological) and immanence (the discovery of the transcendent in the physical/psychological). Religion can be considered as the organized attempt to facilitate and interpret that search (1).

My ideas about the relationship of spirituality to the trauma therapist center around the notion of an innate self. The innate self is probably equivalent to the substance that the alchemist calls the prima materia (original substance). After gathering and bonding together the atomic structure of the physical body, the innate self interacts with the material world (i.e. the environment), and our ideas about ourselves are formed mostly through that interaction. Because our ideas about ourselves are formed through our interaction with the environment, and the environment usually changes in very gradual ways, we believe that change occurs in a gradual, incremental process.

Based on our belief in gradual change, we operate under the illusion that we have an agreement with an omnipotent force which guarantees our invulnerability to sudden overwhelming change. This invulnerability agreement allows us to do very dangerous things, such as drive a car without overwhelming anxiety. But when trauma occurs it is an abrupt, huge, violent change that challenges our incremental notions and shatters the illusion of invulnerability. When trauma occurs our ideas about ourselves are disrupted and new ideas must be formed if we are to integrate the trauma. If the new ideas are not integrated with the deeper feeling of a broken covenant, the new ideas will still be environmentally bound and subject to further significant disruption.

The innate self, because it is not environmentally bound, is more in touch with the fluidity of change. Change can be sudden and enormous as well as slow and incremental. Additionally, the innate self is cognizant of a greater covenant. The greater covenant is the symbol of hope we all have that there is purpose and meaning regardless of the horror.

As trauma therapists we regularly encounter patients who struggle with the purpose and meaning of existence. The horror of nightmarish experiences challenges belief systems of both the trauma survivor and, later, the trauma therapist. We are challenged to find a reason for why such painful, difficult events could happen. For ourselves, as therapists, whether we become involved in orthodox religion, new age crystals, fundamentalist groups, debate societies, entrepreneurial activities, or mystical devotion, we must attempt to find our own answer and aid our patients in their struggle. However, if we choose to believe that spirituality is essential to treatment for trauma survivors, there are several cautionary notes which must be sounded prior to the attempt to incorporate spiritual awareness into treatment.

The therapist must be exceedingly careful to never attempt any type of proselytizing. Regardless of how valid the therapist considers his or her perspective, our beliefs must be put aside in favor of understanding the patient's sense of existence. Even if the patient is searching and questioning, a process that trauma survivors find both essential and exhausting, our role is only as a facilitator not as a director. There must be great respect for the patient's current perspective and the patient's right to not even discuss this very intimate belief.

While the experience of failure is difficult enough for the untraumatized, failing at something as profound as spiritual growth is exceptionally devastating for the trauma survivor...the sense of failure experienced by the survivor in spiritual work is similar to the survivor's experience of blaming the victim.

Secondly, there is the general difficulty of touching onto ground usually thought of as belonging to the ministry. Few psychotherapists have received formal training in spiritual matters. If a therapist is to attempt to help others with their spiritual search it is important that the therapist have a spiritual discipline. But spiritual practices are extremely demanding of one's time, challenging to one's ordinary concepts, and make one more prone to commit the (albeit subtle) error of proselytizing.

If these two admonitions are followed and a spiritual perspective is adopted by

Continued on page 3

Inside this EDITION

FROM THE EDITOR...

Perhaps the most controversial and emotional issue in treatment of psychological disorders is the notion of spirituality. The contemporary fields of counseling and psychotherapy have been founded in the natural science philosophy. The natural science method studies the physical nature of events and eschews questions not confined to the physical. In the treatment field this means we must correlate psychological processes to physical processes. However, just as trauma attacks our well-ordered belief systems, spirituality proposes something beyond both the physical and the psychological. What makes this metaphysical proposal so important is that trauma survivors seem to find in the spiritual an additional possibility of hope and meaning.

As therapists one of our primary goals is to improve the effectiveness of our treatment. Now we are challenged to find ways of incorporating a significant and complicated human need into counseling and psychotherapy. The articles represented in this issue are a current attempt at communicating thoughts and feelings regarding the spiritual component in the treatment of PTSD. All of the authors are experienced trauma counselors and have incorporated spiritual perspectives into their treatment methods.

However, it is frequently difficult to communicate the spiritual as it is not easy to convey in words something that is not physical. Fortunately, the arts are able to "say that which cannot be said." It is along these lines that this issue offers the poetry of several trauma survivors.

Hopefully this issue will act as the stimulator of a forum for further discussion of the spiritual as a component of effective treatment. The more we are able to communicate with each other the less the possibility we will fall prey to "compassion fatigue." Finally I am honored to have been included amongst these contributors and am especially honored to have been guest editor. My special thanks to the regular editor Bruce Hiley-Young for originating this idea, for asking me if I was interested in being part of this issue, for searching through the cyberspace for poetry (how more metaphysical can we get?), and for his genuine, honest, and enlightened direction.

Larry Decker, Ph.D.
Guest Editor

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the therapist, in effect, the therapy becomes more complicated. Spiritual disciplines teach ideals. The student in a particular discipline is given methods which facilitate the realization of these ideals. For example in Christian devotion students are frequently taught to follow the example of Christ who epitomized selfless love. Service and prayer are primary methods in this great spiritual movement. In Buddhism, students are trained to reach enlightenment through discarding the notion of the individual. Meditation and mastery are major techniques in transcending individual limits. Both approaches are deep,

Abstract ideas and metaphysical philosophies will generally not be adequate to reduce the suffering of the traumatized. Spiritual awareness must be intimately personal.

profound, and great truths. Unfortunately it is exceptionally rare for a student to actually realize those truths, integrate the ideals, and apply them in his or her life. Most students are then seen, by others as well as themselves, as having failed. The rationale for the failure is that if the students' dedication or surrender had been greater or deeper the ideals would have been incorporated. While the experience of failure is difficult enough for the untraumatized, failing at something as profound as spiritual growth is exceptionally devastating for the trauma survivor.

The sense of failure experienced by the survivor in spiritual work is similar to the survivors' experience of "blaming the victim." The phrase "blaming the victim" is used to describe the trauma survivor who is perceived as either being at fault for the trauma (having set up a situation, consciously or unconsciously, which helped create the trauma) or when the survivor is perceived as somehow deficient in psychological makeup if he/she demonstrates any emotional difficulties after a traumatic experience. In spiritual teachings, blame and failure are common emotions felt deeply by the trauma survivor. Spiritually "blaming the victim" can take several different forms and must be carefully guarded against and ameliorated when trauma therapists attempt to include spirituality in treatment. Most types of spirituality have an aspect to them which asserts that if something bad happens to you it is because of either punishment from a wrongdoing or because of an attempt by the omnipotent power (God) to stimulate emotional development (e.g. improve sincerity). Punishment can be as all-encompassing as the concept of original sin (we are punished because we are human, because we are human means that we are innately flawed) or even as personal as karmic payback (I have done something bad to someone else either in this life, or in another one, and the trauma is my punishment for that wrongdoing). Punishment as the reason for trauma is generally not helpful in trauma therapy.

Trauma as a stimulator of emotional development is also not a good explanation if the trauma involves the loss of a loved person such as a child. It does not seem therapeutic to assert that a child died so that the parents could become emotionally stronger.

There can be real difficulty if the therapist attempts to use forms of spirituality with which he or she might be unfamiliar. In particular, the Native American religion has many forms and is culturally bound in many ways. Attempts at including these concepts can be damaging to the recovery process unless the therapist is part of that particular culture and has received specific training in that spiritual discipline.

Another related issue is the error of mixing several different spiritual teachings/methods. It is confusing enough to attempt to understand and incorporate one spiritual discipline, but to study several methods at once generally results in increased confusion. Moreover, certain spiritual techniques may not work well when combined with other techniques. This is true even within a particular discipline but is particularly problematic when different disciplines are combined. Spiritual methods are profound and powerful agents which must be well understood in their effects prior to administering them to our damaged patients. The trauma therapist who wishes to incorporate spiritual awareness into his or her work must carefully guard against these very devastating errors.

Survivors turn away from organized religion because it is not personalized. While spiritual teachings are deep, profound, and inspiring the complete application of those teachings is beyond the reach of us ordinary folk. Platitudes and slogans, regardless of their truth and depth, serve only to widen the gap between the survivor's inner torment and adequate living. Instead of being admonished to be someone else, the survivor needs like all of us, to be him or herself. To illustrate this point a Jewish story relates, "Rabbi Zusya said, "In the coming world, they will not ask me: 'Why were you not Moses?' They will ask me: 'Why were you not Zusya?'"

With all of these difficulties regarding the use of spirituality it is no wonder that the main thrust of psychotherapy has not included the concepts of transcendent meaning. However, the trauma survivor has experienced extreme evidence that the world is neither safe nor predictable. The sudden overwhelming proof that the world is a temporary, unpredictable place is difficult to incorporate into existing beliefs. Traditional treatment can be aided by the survivor's direct experience of him or herself beyond his or her ordinary limits.

The job of the therapist for trauma survivors is to help the survivor see that the very horror which resulted in their deep agony is also what gives them access to the release from their existential dilemma. Everything physical is temporary and combat veterans know this fact in ways that most civilians can only imagine. Having direct experience of our temporary nature can help in the realization of how we are connected to eternity.

Anyone who attempts to examine their life will be confronted with our temporary status and the obvious existential questions of purpose and meaning. But the trauma survivor must confront these questions in very direct ways. Abstract ideas and metaphysical philosophies will generally not be adequate to reduce the suffering of the traumatized. Spiritual awareness must be intimately personal. It must celebrate our imperfection. It must provide relief from despair and hopelessness. It must comfort us and it must be real. It must provide us with direct experience of our continuity and our unity.

Beliefs direct our ideas and select our choices for our awareness. Those very beliefs are what are shattered by the trauma experience. If the therapist simply helps the survivor reconstruct new beliefs which are also based on the interaction with the environment, very little of long term recovery will have been accomplished.

In his book, *Living Presence,* Kabir Helminski discusses the basic trauma of human life—the awareness that we are separate and individual—"Human beings stand in the rubble of former beliefs. We finger through the shards of meaning trying to imagine what the whole might have been like" (2). An eloquent statement that could describe most trauma survivors.

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A version of this paper was presented at the Tenth Annual Meeting of the International Society for Traumatic Stress Studies, Chicago, IL., November, 1994.

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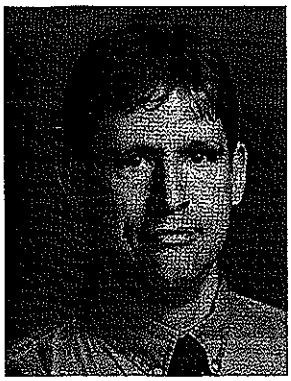
SPIRITUALITY AND TRAUMA TREATMENT: SUGGESTIONS FOR INCLUDING SPIRITUALITY AS A COPING RESOURCE

Kent D. Drescher, M.Div., Ph.D. and David W. Foy, Ph.D.



Kent D. Drescher, M.Div., Ph.D.

Religious beliefs and practices (spirituality) are traditions through which many people develop personal values and their own beliefs about meaning and purpose in life. Among mental health professionals, there is increasing recognition that many patients view spirituality as a primary human dimension. Indeed, current concepts of coping strategies are evolving to include spiritual beliefs and practices, along with other social, emotional, physical, and cognitive aspects, as important coping resources. The military has a long tradition of providing for the spiritual needs of its troops through Chaplains representing Jewish, Catholic and Protestant religious traditions. In his review, Donahue (1) found many studies which show generally positive relationships between religion and both mental and physical health. In particular, regular religious practices (as opposed to specific beliefs) such as church or synagogue attendance, prayer and scripture reading, have been shown to be related to positive mental and physical health.

Traumatic events often lead to dramatic change in survivors' world views so that fundamental assumptions about meaningfulness, goodness, and safety shift negatively. For those whose core values are theologically founded, traumatic events often give rise to questions about the fundamental nature of the relationship between the Creator and humankind. How can belief in a loving, all-powerful God be sustained when the innocent are subjected to traumatic victimization?

In a recent study (2) it was suggested that religiously committed women who are battered suffer less severe PTSD symptoms than women without such commitment. However, research also indicates that battered women attend religious services less frequently than maritally distressed controls (3). This finding is consistent with research related to combat veterans which suggests that those experiencing psychiatric problems or PTSD attend religious services less frenquently than controls (4).

The goal of this article is to provide suggestions for incorporating spirituality as a core component in coping resources assessment or relapse prevention work for traumatized populations. Over the past year we have been studying veterans in treatment at the Menlo Park and Brentwood PTSD inpatient treatment programs. To date we have studied the responses of about 100 patients to the 14 item Age Universal Religious Orientation Scale (5). What we found is consistent with earlier findings. Vietnam combat veterans with PTSD score lower than average on measures of religious orientation (6). It also suggests that they are less likely to use religion as a way of getting social support when they need it. We also inquired about other aspects of their religious faith. Table 1 shows these items and mean response rates. These results show that most patients had difficulty reconciling their religious beliefs with their experience in combat. However, about 26% of patients said that combat experiences made their faith stronger. For these particular patients, this statement was strongly associated with current church attendance. To summarize, current spiritual practices appear to be heavily influenced by two factors: childhood religious participation, and combat-related religious conflicts. For those individuals who want to work on their religious participation as a means of improving their coping resources, we have developed several intervention strategies which might be incorporated into existing group treatments.

David W. Foy, Ph.D.

GUIDELINES FOR INCORPORATING SPIRITUALITY INTO GROUP ACTIVITIES

To institute a spiritual component, two ground rules are critically important: strictly voluntary participation, and mutual respect for divergent views. Patients' views of spirituality can be highly personal and emotionally charged, ranging from seeing spirituality as unimportant to it being a

Table 1. Responses of PTSD inpatients to items related to religious faith

ITEM:	AGREED%:
Religious faith was an important part of my life during childhood.	60%
I have had difficulty reconciling my religious beliefs with the traumatic events that I saw and experienced in Vietnam.	74.4%
I abandoned my religious faith in Vietnam.	51.0%
Experiences in Vietnam made my faith stronger.	25.8%
I have abandoned my religious faith since my return from Vietnam.	45.1%
Experiences since I left Vietnam have caused my religious beliefs to grow stronger.	33.6%
Feelings of guilt about things I experienced in Vietnam have caused my religious faith to diminish.	50.5%
While I was growing up, I attended church or religious services: (>2x per month)	73.8%
In Vietnam, when it was possible, I attended church or religious services: (>2x per month).	18.7%
I currently attend church or religious services: (>2x per month).	26.1%

Current spiritual practices appear to be heavily influenced by two factors: childhood religious participation, and combat-related religious conflicts.

central focus of life. These factors make it essential that participation be voluntary. Discussion of sensitive and delicate issues must allow for wide ranging differences in attitudes and beliefs. Thus maintaining a tone of interest in and mutual respect for the views of others is a necessity. Emphasis is placed on aspects that varied religious traditions share, rather than on those which separate. Acknowledgment of the varied contributions of each religion and culture represented should be made and a tone of acceptance set by group leaders. As with all trauma groups, the group should provide a safe environment for emotional expression and self-disclosure.

A Menu of Possible Group Activities

A variety of spiritually based activities are possible: a spiritual autobiography, discussion of key existential issues, silent prayer and meditation, guided imagery, practice in religious ritual, use of selected readings, and attendance at religious services.

Spiritual Autobiography: Patients are asked prior to group to write a description of their spiritual journey from childhood to the present. This highlights key experiences and decisions which were made regarding their religious faith and describes the context in which they occurred. This exercise allows patients to clarify and see more objectively their current religious beliefs and practices and reflect on directions they would like to pursue. Autobiographies are presented in turn by group members during sessions and help identify and begin discussion of relevant themes and issues.

Discussion of key issues: The group focuses on the discussion of key theological and existential issues. A portion of each group session is devoted to exploration of issues which are relevant for the group. Facilitators need to be able to inform the group how various traditions have resolved these issues but leave it to group members to wrestle the questions through toward their own individual solutions. Issues might include reconciling the existence of God with the presence of evil and suffering in the world, processing feelings of anger at perceived abandonment of betrayal by God. Additional issues might include shame, forgiveness, guilt, and self-blame. Participants are asked to reflect about their own religious upbringing and what they learned as children about these issues.

Spiritual exercises: A variety of experiential exercises involving meditation, guided imagery, and silent prayer are appropriate. These should include a relaxation component which will build upon existing stress management skills already learned and used by the patients. Exercises are drawn from a variety of religious traditions. In addition, outside "practice" of prayer and meditation exercises experienced during group sessions is encouraged.

Selected readings and religious ritual: A varied collection of suggested readings is compiled by group members and a file maintained by facilitators. Reading is assigned as homework and members are asked to keep a journal recording their thoughts about the readings and other group experiences. Throughout the sessions the importance of religious rituals is emphasized. Many theological traditions have made use of rituals to communicate meaning through imagery and metaphor. Leaders can encourage group members to discover meaningful rituals in churches they visit. In addition, the group can create a unique ritual which might express something of the issues explored during the course of the group. The group should then enact the ritual at some point, perhaps near the end of the group meetings.

Religious participation outside group: Group members are encouraged to attend a religious service of their choice. The purpose is to desensitize this experience for members for whom this is difficult and it may facilitate development of an outside network of social support in the community.

ULTIMATE GOALS

The ultimate goal for the individual participants is the recovery of a sense of hope, and a more realistic balanced view of the world as a place of both danger and safety, evil and good. Facilitating patients' re-connection with the roots of their childhood faith or discovering new avenues of religious expression may provide ongoing meaning and comfort. Patients may also identify spiritual practices which ultimately provide release from guilt, comfort for pain and loss, and support for the struggles of healing which lie ahead.

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SOME THEOLOGICAL PERSPECTIVES ON PTSD

William P. Mahedy

William P. Mahedy

My specialty in PTSD is combat trauma. As a subspecialty, I have dealt extensively with combat atrocities and assassinations connected with clandestine operations. As might be expected, the unresolved moral and religious residue of this kind of activity is enormous. Morality and religion are issues that seem inescapable in PTSD work with veterans.

Religious and moral issues arise in a variety of ways and from a multiplicity of religious backgrounds in our pluralistic culture. Each religious perspective has something to offer and I would like to see members of different traditions address PTSD from their own vantage point. My own religious background is Christian so I write from that frame of reference. Most of my clients were at one time in their lives members of a Christian church so I find this religious tradition useful for many veterans.

American Christians who engage in war, and especially those who commit atrocities or assassinations, are caught between the mythology of civil religion and the teachings of their religious faith.

As a former army chaplain and Vet Center team leader, I have experience in combining "moral theology" with the modalities commonly used in treating PTSD. Presently, I am running a "spiritual issues" group for combat veterans in San Diego.

Though some therapists continue to work with issues related to combat, most PTSD therapy now deals with other problems. I have found that work on combat related issues provides insights into the religious and moral questions that arise from other stress producing situations. In this brief article, I would like to share "theological reflections" on my experience and some brief suggestions hoping these will be useful to therapists whose clients are combat veterans or other survivors of trauma. Included are biblical passages I have found helpful in working with clients from a Christian background.

THE MORAL DIMENSION

No one knows better than the soldier who has committed atrocities or performed assassinations that these acts have irrevocable and enduring consequences. People are dead and maimed, villages destroyed. Personal responsibility for such actions cannot and should not be denied. The great moral discovery in a combat zone is that of one's own limitless capacity for malice, and, by extrapolation, the unsuspected depth and pervasive nature of human depravity. A veteran who has been personally involved in atrocities or assassinations must live with this knowledge for the rest of his life. Some assessment of this responsibility is a necessary concomitant of therapy.

PRACTICAL SUGGESTIONS FOR ADDRESSING SPIRITUAL ISSUES RELATED TO COMBAT

1. Help the veteran to recount exactly what happened as he remembers it, allowing the feelings to come out.

2. Help the veteran to assess what he knew and understood and felt at the time. For example, what would have happened if he hadn't "gone along with the program in shooting up the village." Would he have been killed himself? Could he have fired over the heads of his victims instead of at them? How much was emotion, the rage of combat, revenge for atrocities committed by the enemy? How much was cold blooded murder? Was he on drugs at the time of the killing? It must be noted that atrocities are often fueled by a desire for revenge, but assassination is premeditated.

3. Suggest to the veteran that he accept responsibility for only what he actually did. He must not self-impose a sentence of "first degree murder" if it was only second degree. On the other hand, if it was gratuitous killing or cold-blooded assassination, then one must accept that fact and live with it.

4. Guilt must be changed into animating guilt. One's life must be altered, transformed. Where before the soldier was an instrument of death, the veteran must now become a bearer of life. This involves the classical notion of atonement, repentance. It is an essential component of successful therapy for veterans who have been involved in abusive violence or assassination.

5. Encourage the veteran to forgive all enemies—simply walk away from hatred. This is, of course, so difficult to do that it becomes the work of a lifetime.

THE RELIGIOUS DIMENSION

Americans live in what has been called " a nation with the soul of a church." From our colonial beginnings, we have invested our political system with a religious aura. Our early ancestors believed they had established a "city on the hill," which would be a moral and religious beacon to the rest of the world. These early settlers described the new political experiment in terms previously reserved for the biblical people of Israel. This vision of America has survived until the present as a form of "civil religion." All nations have some sort of civil religion, but ours uniquely identifies itself with Jewish/Christian biblical faith.

War has played a major role in our national history. We achieved status as an independent nation through world war. The role of the citizen soldier in our history has reached mythic proportions. American Christians who engage in war, and especially those who commit atrocities or assassinations, are thus caught between the mythology of civil religion and the teachings of their religious faith.

The God of American civil religion is an aggressive God, who goes with the troops into combat, delivers them from evil and, above all, assures them of the rightness of their cause. The truth about combat is quite different, however. God seems malignantly absent in the caldron of madness, savagery and malice that is war. Grace, redemption, mercy, kindness, love of neighbor—the stuff of New Testament faith—are incompatible with the killing rage of combat. Though veterans of all wars have faced these issues, it was Vietnam that brought them to public notice.

A cognitive or "theological" grasp of the problem is a necessary adjunct to PTSD therapy for veterans. Religious questions must not be cloaked under another guise, but should be confronted directly. Most PTSD clients with religious questions already have some understanding of the disjuncture between their actions and their belief system. They should be encouraged to probe even more deeply.

Situations that cause PTSD are often so severe that they alter one's view of life. This is true of combat. Previous world views are no longer adequate after the experience. The question that most often arises is "where was God?" It is at this point that American civil religion is most harmful. The macho God who fights for us in war, becomes in a peacetime consumer society the God who is there to assure us that life should meet all our expectations. God thus becomes a kind of grantor of material success and personal fulfillment. Religion of this kind is the "happy face, " " have a nice day, "variety. It helps to remind the veteran or other client that this has very little to do with the Christian biblical tradition.

PRACTICAL SUGGESTIONS

a. The suffering of Job: a distinction.

Job suffered terrible afflictions. His friends were convinced that his sufferings could only be the result of punishment for sins. Job insisted upon his innocence and asked God for an answer. God never gave a straight answer, but rather an experience of transcendent divine presence that stilled Job's question (Job: 38-42). Job is very useful in dealing with PTSD clients. Some clients, i.e., innocent victims of war, victims of sexual abuse and rape are, like Job, completely without guilt. Others, i.e., assassins and those who have committed atrocities, are clearly not innocent. I have found that therapy is enhanced if the client searching for religious answers understands this distinction at the very beginning of therapy.

b. The suffering of the innocent.

Much of therapy with innocent victims of war, victims of sexual abuse and rape is, quite rightly, devoted to helping the person overcome feelings of guilt. The religious corollary to this kind of therapy is to help the client to relate to the suffering of the innocent. In this regard, I have found helpful the biblical story of Jesus on the cross. Similarly useful are the statements of Paul that we are called to be sharers of the divine nature and children of adoption.

c. God's love of the guilty.

For combat veterans who have done much killing, for those who have committed atrocities or assassinations, the innocent suffering of Job does not apply. But I have found several biblical passages to be most helpful. Christ called Saul of Tarsus from a mission of death and destruction to be one of his followers (Acts 9:1-30). The prodigal son squandered his inheritance and wanted to return to his father as one of his servants. He was offered instead complete restoration as a much loved son and a fine party thrown in (Lk 15:11-32). The shepherd leaves the ninety-nine sheep and goes after the one that is lost. (Mt. 18:10-14).

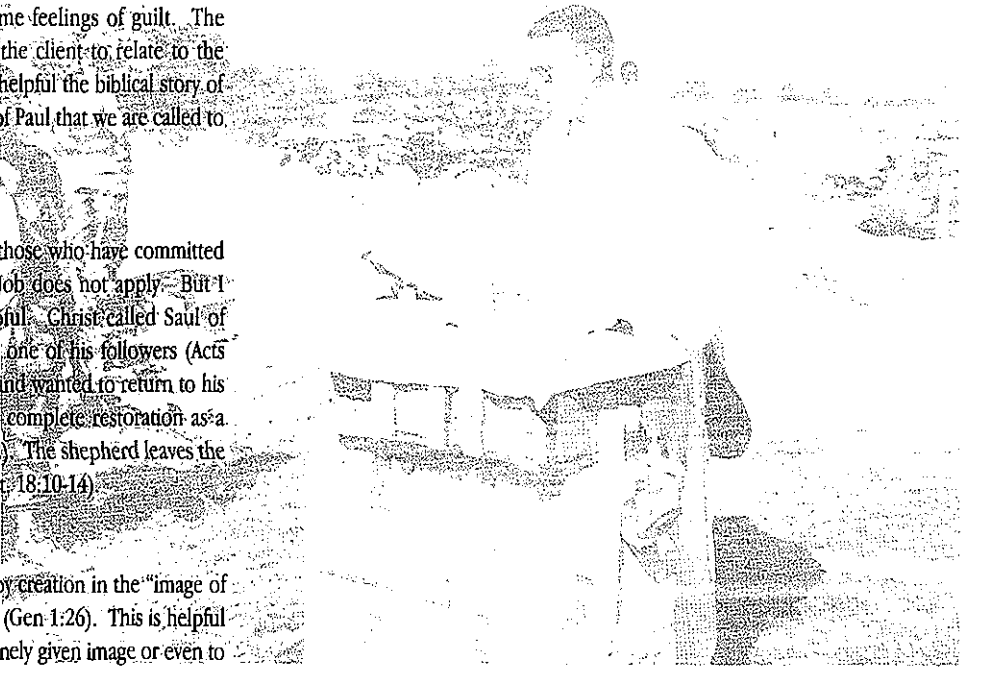
d. The image of God.

The religious tradition offers a self-esteem given once by creation in the "image of God" and then offered again through "a new creation." (Gen 1:26). This is helpful to a therapist who is helping a client to recover this divinely given image or even to realize it for the first time.

We who work in of the field PTSD have made a difficult professional choice, but most of us probably wouldn't do anything else. We know from personal experience about stress, burnout and the other ways in which our work takes its toll upon us. Many of our clients have fallen by the road of life, beaten down and unable to continue their journey. Some are unable to get up and move along with our intervention. I will end with a reflection appropriate to us and what we do.

When asked to explain the meaning of the biblical injunction to love your neighbor as yourself, Jesus responded with the story for one who had fallen by the side of the road, having been beaten by robbers. Two people passed by and did nothing. But the third passerby stopped and helped the victim (Lk 10:25-37). In the Christian tradition, this story has become the embodiment of how one lives out the command to love one's neighbor. Paul put it another way: *"Bear one another's burdens and in this way you fulfill the law of Christ" (Gal 6:2).* I see ourselves and our work in this context.

Dr. Mahedy is a readjustment counselor and chaplain for a residential treatment center operated by Vietnam Veterans of San Diego, a non-profit organization. He is an Episcopal priest and served as an army chaplain in Vietnam. Dr. Mahedy has written several books including A generation alone (co-author, Janet Bernardi, Intervarsity Press, 1994), and Out of the night: The spiritual journey of Vietnam vets (Ballatine Books, 1986).



NEW DIRECTIONS

Matthew J. Friedman, M.D., Ph.D.
Executive Director, NC-PTSD

Last fall the National Center for PTSD celebrated its fifth birthday. In view of the milestone, I'd like to review some of the highlights of those first years.

There wasn't much to guide us when we started out. Congress had enacted legislation mandating that a National Center take the lead in research and education on PTSD. The impetus for this legislation had come from veterans and veteran service organizations striving to upgrade the VA' capacity to understand and treat war-related psychological problems of veterans seeking VA care. Therefore, it was clear from the outset that our primary responsibility was to support clinical programs and clinicians providing treatment for veterans with PTSD related to their military experience. It was also clear that we were expected to take the lead in research on the etiology, epidemiology, assessment, and treatment of PTSD. We have worked hard to achieve these goals. Later in this article, I'll mention some of the major research and educational programs that we have initiated in order to meet this Congressional mandate, support VA programs, and improve our scientific understanding of PTSD. Our ultimate goal, of course, is to help veterans who develop PTSD during military service.

Although this will always remain our major focus, a number of important and unexpected events during the past five years have had a profound impact on both our research and educational priorities. These events have helped us define our own concept of what the National Center should be doing. They have also prompted us to develop many new programs that were inconceivable when we first began to operate in 1989.

The Loma Prieta earthquake in October, 1989, was literally a shocking surprise that destroyed the main hospital building at Palo Alto and shook up the National Center's Education Division at Menlo Park. Within days after this event we established post-disaster debriefing and psychoeducational initiatives throughout the California South Bay area, including a clinic in Santa Cruz and a program for VA personnel who had themselves been affected by the earthquake. Since then we have provided both hands-on and educational assistance in a number of natural disasters, including Hurricanes Andrew and Iniki and the recent Northridge earthquake. Program planning for natural disasters has become a major priority of the National Center. In addition, we have been working on an intergovernmental task force to develop a national mental health disaster plan that would be activated immediately after any natural disaster. Other members of this task force include representatives of the Department of Defense (DoD), the Surgeon General's Office, Public Health Service, FEMA, Red Cross, and VA (Emergency Medical Preparedness Office and Readjustment Counseling Service (RCS).

Operation Desert Shield/Storm (ODS) provided the second unexpected major event to impact our agenda. National Center staff served as advisors and faculty as VA Medical Centers prepared to receive up to 50,000 fresh combat casualties from the Persian Gulf War. Fortunately, this worst case scenario never materialized yet it did transform our focus from an exclusive emphasis on chronic PTSD to a more practical consideration of the impact of exposure to acute trauma. We were already moving in this direction following our experience with the Loma Prieta earthquake but ODS propelled us along this path. We quickly published an ODS clinician packet that included articles on assessment and treatment of acute military trauma. Since then we have worked with RCS and DoD on assessment and debriefing of American forces who participated in the Persian Gulf War and in peacekeeping operations in Somalia.

A third major initiative concerns education, research, and treatment of female veterans exposed to sexual assault during military service. This had been an important focus for the National Center from the outset, but during the past five years this program has expanded to such an extent that we established a new division, the Women's Health Sciences Division in Boston, to devote exclusive attention to the post-traumatic problems of female veterans. In addition, we established a first-in-the VA inpatient unit for treating women veterans at Palo Alto. Attention to sexual assault inflicted on adult women led inevitably to program initiatives on childhood trauma, both sexual and physical abuse. There is currently at least one project dedicated to the impact of childhood trauma at almost every division of the National Center. We are learning that a substantial number of male as well as female veterans with PTSD were abused as children and we believe that this early exposure to trauma may have increased their vulnerability to develop PTSD subsequently during military service.

A fourth initiative concerns education, research, and treatment on the unique problems of veterans from ethnocultural minorities. Initially, we were mandated by Congress to investigate lifetime and current prevalence rates of PTSD among Asian-Pacific Islander and American Indian Vietnam veterans. We also established our seventh division, the Pacific Islands Division in Honolulu, which emphasizes research and education on how cross-cultural factors affect the expression, detection, and treatment of PTSD. This is also a major focus at our Education Division at Palo Alto. In 1993, the National Center convened a conference on ethnocultural factors in PTSD, the proceeding of which will be published as a book by the American Psychological Association next summer. Finally, in partnership with RCS, the National Center sponsored a conference on PTSD among African American veterans, held in St. Louis last year. The momentum from that conference has resulted in an RCS/National Center joint initiative with Howard University Medical School to develop treatment approaches for African-American veterans with PTSD.

I have singled out these four program initiatives because they have become such an important part of our ongoing activities. There are other new foci that undoubtedly will grow in importance in coming years. Two that come to mind are multisite trials of different treatment approaches for PTSD and the relationship between PTSD and medical illness.

It is important to emphasize, however, that all of these new initiatives are embedded in our ongoing research and educational programs. Our psychological, psychophysiological and neurobiological research continues to lead the field world-wide. Our program evaluation of VA inpatient and outpatient PTSD programs continues to provide coherence, continuity, and networking for VA clinicians. Our two newsletters, The PTSD Research Quarterly and the NCP Clinical Quarterly each have a circulation of approximately 6,000. Our PILOTS database has now indexed over 7,000 titles and is available free of charge through the Internet and in other ways.

National Center staff are continually available to VA clinicians and investigators for consultation on treatment, research, or program development. Most important of all, we eagerly look forward to new challenges and opportunities during the years to come.

A SPIRITUAL PERSPECTIVE ON TRAUMA AND TREATMENT

Merle R. Jordan, Th.D.

Merle R. Jordan, Th.D.

Traumatic events tend to raise spiritual questions. When parents lose a child, it is not uncommon to hear the bereaved ask "why, God?" Questions regarding injustice, unfairness, meaning and purpose emerge raising issues about the struggle between the power of good and evil. How can God be a loving God when the Holocaust occurs, when incest and rape take place, when innocent people die from the ravages of war, natural disasters, hunger, poverty, sickness, oppression, etc.? A Vietnam veteran describes his loss of faith...

"I could not rationalize in my mind how God let good men die. I had gone to several...priests. I was sitting there with this one priest and said, 'Father, I don't understand this: How does God allow small children to be killed? What is this thing, this war, this bullshit? I got all these friends who are dead. . . .' That priest, he looked me in the eye and said, 'I don't know, son, I've never been in war.' I said, 'I didn't ask you about war, I asked you about God.' "

Herman (1)

Whether a clinician is an avowed religious person or not, a clinical perspective cannot overlook agonizing spiritual questions.

Whether a clinician is an avowed religious person or not, a clinical perspective cannot overlook agonizing spiritual questions. From a secular perspective Herman (1) suggests that trauma challenges one to become a theologian. Beyond the unfathomable question of why it happened, the survivor confronts another equally incomprehensible question... "Why me?" The arbitrary, random quality of his or her fate defies the basic human faith in a just or predictable world order. Trauma tears at the very fabric of one's faith. To develop a full understanding of the trauma story, the survivor must examine the moral questions of guilt and responsibility and reconstruct a system of belief that makes sense of the undeserved suffering.

TRAUMA IS A GOD

Trauma's dominating forces can absorb the attention of some victims as if the trauma itself was good.

"Whether a divine being really exists or not, the psychological fact remains that we tend to experience traumatic events as if they were in some sense divine. Just as God has been described as transcendent and unknowable, a trauma is an event which transcends our capacity to experience it. Compared to the finite nature of the traumatized soul, the traumatic event seems infinite, all-powerful, and wholly other. Again, we cannot say that traumatic events literally possess these properties, but only that the traumatized soul propitiates them as if they did. ....So long as the overwhelming event is at least slightly larger than the soul's capacity to absorb it, it will be construed as infinite."

Mogenson (2)

The horrifying subjective reality caused by the trauma becomes the experience of the nature of the truth about external reality. Doehring's (3) study of women abused as children found that abuse, in effect, resulted in a desecration of a woman's inner sanctuary, and was a significant factor in her developing world view and mental representation of God.

Trauma causes the survivor to experience that she or he lives in a universe governed by some horrendous evil if not demonic force. The fixation around the false absolutes created by trauma leave one trapped in a perceived world governed by false gods. One's identity and sense of self in the world become dictated by these false gods. One's being in the world has been named by something other than the Source of life. Therapy with survivors needs to involve the therapist's ability to confront the false gods and destructive belief systems that are dominating the psychic world of such survivors.

REFRAMING OF PERCEIVED ULTIMATE REALITY

One has the challenge to frame the terrible traumatic events into a new crucible of meaning.

"An educated and contained image of the events of one's life, before, during, and after victimization potentially frees one from constructing a view of oneself and humanity solely on the basis of the victimization events. For example, having been helpless does not mean that one is a helpless person; having witnessed or experienced evil does not that the world as a whole is evil; having been betrayed does not mean that betrayal is an overriding human behavior; having been violated does not necessarily mean that one has to live one's life in constant readiness for its reenactment; having been treated as dispensable does not mean that one is worthless; and taking the painful risk of bearing witness does not mean that the world will listen, learn, change or become a better place."

Danieli (4)

Trauma's dominating forces can absorb the attention of some victims as if the trauma itself was god.

The survivor's need for others to embody a loving reality in the midst of fear is depicted in the familiar story of a little girl named Maria. Maria's mother was a devout, religious woman, who was trying to raise her daughter with a sense of love and acceptance. She didn't wish for Maria to become a fearful person. The

essence of the mother's teachings was, "God loves you, God will guide you, God will protect you. You never have to be afraid." But one night there was a terrible thunderstorm. Maria was in her bedroom by herself, nose pressed to the windowpane, while lightning zigzagged and thunder crashed.

"Mommy, Mommy, I'm scared," she cried out.

"Now, Maria," her mother said, "Haven't I taught you that God loves you and protects you and you never have to be afraid of anything?"

To mediate hope in the midst of the apparently contradictory evidence of death and destruction may seem like an awesome responsibility for the clinician, but we are called to this monumental task of revealing the authentic optimistic spiritual reality by our very being and doing.

"I know, Mommy, I believe all that. But tonight I need someone with skin on." The trauma survivor needs a therapist, a care giver with "skin on" who mediates in one's very being a radically different reality than that revealed in the trauma. Whether the clinician is aware of it or not, she or he is reflecting what the nature of ultimate reality is to the patient. The therapist is communicating in being and in doing whether the fundamental principle of the universe is love and grace or fear and betrayal. The loving, accepting, affirming being of the therapist is revealing the authentic nature of Being itself. Oden (5) has suggested that "a good therapist is the shepherd of being, witnessing to the trustability of being itself, not by mere words but through a living relationship."

It is not an easy task to help survivors challenge their beliefs that evil, horror, betrayal, untrustworthiness and terror are the basic truths of life. To mediate hope in the midst of the apparently contradictory evidence of death and destruction may seem like an awesome responsibility for the clinician, but we are called to this monumental task of revealing the authentic optimistic spiritual reality by our very being and doing.

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THE FOUR CHAPLAINS

During the early hours of February 3, 1943, the U.S. Army troop transport, Dorchester, was struck by torpedoes in the icy waters off the coast of Greenland. Many on board were killed instantly and with the vessel listing badly, the Dorchester's captain gave the order to "abandon ship." Stunned by the explosion, survivors groped their way to the upper deck leaving behind warm clothing and life jackets. Several of the lifeboats had been destroyed. Those that were successfully launched pitched wildly in the cold North Atlantic.

Among the nine hundred men on board, were four chaplains: George L. Fox, Methodist; John P. Washington, Catholic; Clark V. Poling, Reformed; and Alexander D. Goode, Jewish. As the waters began flooding the ship, these four men responded by handing out life jackets, giving directions for abandoning ship, and giving reassurance to the panic stricken. Each of the four chaplains removed their own life jackets to give to someone else. In less than thirty minutes, the four chaplains and six hundred others aboard went down with the ship.

The Weather of this Place

-for RDK

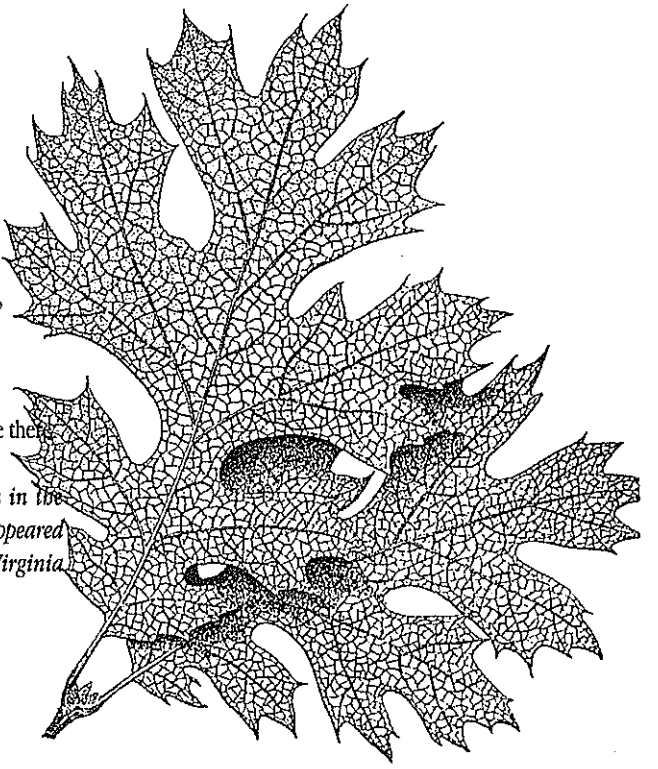
Here, we too have reds,
leaves turning into something like beauty
or the beginning of a day after heat.
Sailors delight travelling the same stars,
over the bones of fellows travellers
like so many pick-up sticks on the ocean floor,
drowned in charted waters, or not-

death is the same, even in a stange country.
Here, the wind kisses our bluffs
with acid lips, the volcanoes have an ulcerous quake,
the sun boxes our children's ears
and burns the chinaberry,
scarring its branches into the fossil earth.

We too have heard of kindness,
a gentle rain that washes the earth
before it's baked into crumbling runnels
the ants run by day, the snakes at night:
In bright July, when emptiness
rings the place to deafness,
the moon's blank face clears for a moment
and silvers the barrens-
such a cool light in which the unexpected
descends, like love or an introduction

to a foreign place.
Sometimes, once or twice a year,
a calm light falls over a shoulder, or the wind
rubs warm, like a finger across your palm
and over your wrist

and that is when you know, in our strange place,
that one might go on. That in our world,
unlike yours, something like hope doesn't fall
casual as weather each year
on dirt so firmly packed it seems it will always be there.



Lisa Gade is a poet and survivor who lives in the Boston area. Her poems have most recently appeared in Agni, The Southern Poetry Review, The Virginia Quarterly Review and Kalliope.

SPIRITUAL HEALING AND PTSD

Philip G. Salois, M.S.

Philip G. Salois, M.S.

Twenty-five years ago I was drafted and sent to Fort Ord to train as a combat infantry soldier. It certainly was no mystery to me or anyone else that I would end up in the jungles of Viet Nam. I served with a Light Infantry Brigade experiencing combat, the loss of a few friends, and the earning of a Silver Star for leading a rescue mission. I never sustained physical injury, but the war impacted my psyche and my soul.

As a result of a battlefield promise made to God on March 1, 1970, I am an ordained Priest. Curiously, I had forgotten that promise made during intense battle, until two years into my seminary training four years later. And though I went into the seminary on my own free will and not under the obligation of fulfilling a promise, I have come to believe that God rescued me from the war for some special work or mission. This realization has not made the on-going work any easier, but it did provide the quiet strength I needed to begin my own long and painful pilgrimage of healing.

I have been ordained 10 years now and as I hoped, I have had the opportunity to work with veterans. After five years of working with Vietnam veterans, I increasingly understand spirituality's significant role in the holistic picture of healing. The majority of Vietnam veterans were raised in Judeo-Christian families with a view of God as a father-image, that is, the strong, stern disciplinarian capable of inflicting severe punishment. In these families, the difference between right and wrong was clearly defined for children and it was defined within religious parameters. Adolescents going to war brought with them their adolescent concept of God. For many young soldiers, their concept of God was tested, challenged and potentially destroyed by the magnitude of evil all around them. In Vietnam, soldiers discovered that their concept of God did not provide answers or explanations for what they were going through. For many, the experience of the war shattered their religious concept of right and wrong. For many, the exposure to evil resulted in deep feelings of guilt and shame.

The approach to spiritual healing with Vietnam veterans requires much care, and even caution, as many of these veterans view God as a helpless, non-caring outsider watching it all from His heavenly throne.

REFOUNDING OF THE SACRED STORY

My work is to help the veteran to refound his or her sacred story. I make deliberate use of that word re-founding because for many their sacred story was lost on the battlefield. The process of re-founding of one's sacred story is one of a journey away from an adolescent view of God toward a more mature understanding of faith and God's role in the course of humanity. It begins with helping the veteran to discover where and when the connection was lost. This encounter is prerequisite to any authentic reconciliation with God as knowledge and understanding must precede forgiveness and reconciliation.

To help the process of reconnection, I have developed two interfaith healing services: one for male Vietnam veterans entitled "WELCOME HOME SERVICE," and one for women. The women' service, entitled "WOMEN OF FAITH/ WOMEN OF VALOR" has included veteran and civilian women who served in Vietnam, Vietnamese women, as well as wives, widows, and mothers of veterans. In each service the altar holds various artifacts to reflect aspects of the Vietnam experience. In the past I have used ***The Book of Names*** (on The Wall), a replica of the The Wall; a replica of the Three Service Men Statue; an actual piece of the Hanoi Hilton, framed pictures of the Eight Viet Nam Nurses whose names are on The Wall, and other religious and patriotic symbols as well.

The approach to spiritual healing with Vietnam veterans requires much care, and even caution, as many of these veterans view God as a helpless, non-caring outsider watching it all from His heavenly throne.

Combining the power of ritual and symbol, there are many activities that can aid veterans spiritual healing process. My own personal healing has included visits to the Vietnam Veterans Memorial "The Wall" in Washington, DC bringing flowers, letters and taking a rubbing of a name; a return to Vietnam with other veterans for the purpose of healing; a visit to the parents and grave of my buddy who was killed in 'Nam (recounting the events of his death proved healing for his parents as well). I am not recommending that other veterans pursue this same path. There are hundreds of creative ways for veterans to receive healing-from writing to participating in Sweat Lodges. Every veteran must find the form of healing appropriate to their experience and ability. My role is to help them discover the options available to them.

It is crucial that something in the form of a spiritual healing take place. Disillusioned veterans need to regain the capacity to hope- - HOPE IN THEMSELVES - IN LIFE - IN OTHERS - IN GOD. As someone said - we might have to hope for the vet until he or she can begin to hope for himself.

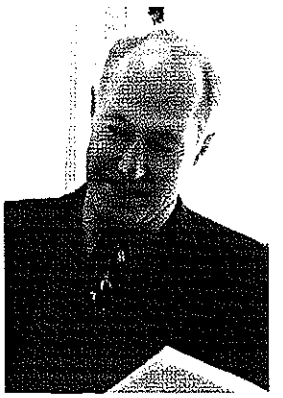
Father Philip Salois is Chief, Chaplain Service, Boston VAMC and President National Conference of Vietnam Veteran Ministers. Fr. Salois served in the U.S. Army in Vietnam from 1969-70 as a combat infantryman with the 199th Light Infantry Brigade.

CLINICAL IMPLICATIONS OF THE POSTTRAUMATIC STRESS DISORDER DSM-IV DIAGNOSTIC CRITERIA

Suzanne Sutherland, M.D. and Jonathan R.T. Davidson, M.D.

Suzanne Sutherland, M.D.

Posttraumatic stress disorder (PTSD) is one of the few psychiatric disorders where the definition is etiologically based as opposed to a phenomenologically-defined syndrome. As such, it is fundamentally concerned with the concept of a traumatic stressor and carries implications concerning the relationship between environmental stressors and psychiatric illness. The DSM-III-R defined the parameters of a traumatic event as one that is "outside the range of usual human experience" and "would be markedly distressing to almost anyone." This in part reflected a desire to reduce the possible trivialization of the disorder that might result from including symptoms resulting from "everyday" events. Unfortunately, normative data do not exist with regard to these parameters. A second problem with this definition is that it disallows the possibility of lower magnitude stressors, perceived as traumatic in some susceptible people, causing full-blown PTSD symptoms. A third problem is that such obviously traumatic stressors such as rape and childhood sexual abuse, assault and battery, and even military trauma are such a common part of human experience in our society that it is hardly legitimate to include them in the category of "outside...usual human experience." In the new DSM-IV criteria for PTSD, the description of what constitutes a traumatic event has been made more explicit by specifying that the stressor must involve actual or threatened death or injury, or a threat to physical integrity. The concept of the stressor has been expanded by including not only events that the person has experienced, but also events that have been "witnessed" or that the individual "has been confronted with." An additional change to this criterion explicitly states that the person's reaction to the event must involve "intense fear, helplessness or horror" as contrasted with the former "that would be markedly distressing to almost anyone." These changes in the traumatic stressor definition carry important implications for diagnosing PTSD, both by expanding the realm of possible events that qualify as traumatic stressors and by dictating the subjective responses that help to distinguish whether an event is truly traumatic for the person being assessed (see Table I for a summary of the changes in DSM criteria). For example, a daughter is called to the sick bed of her elderly mother who is hospitalized in another city. The daughter has known that her mother has cancer and that is has spread, but she has not seen her in several months. She is shocked by her mother's appearance and reacts with horror as she instantaneously realizes that her mother is now in imminent danger of death and that her altered appearance reflects actual harm to her physical integrity as a result of the life-threatening disease. If the daughter's reaction involves intense fear, helplessness, or horror, this event qualifies as a traumatic stressor.



Jonathan R.T. Davidson, M.D.

The criterion B "intrusive and recxperiencing" symptoms are the hallmark of the PTSD definition as they directly refer back to the causative traumatic stressor(s). In DSM-IV, the definition continues to specify that at least one of these symptoms must be present and expands the number of possible symptoms to five with the addition of "physiological reactivity upon exposure to internal or external cues that symbolize or resemble an aspect of the traumatic event." This symptom was formerly part of the D criterion. Including it here allows, for example, anxiety symptoms such as panic attacks in response to traumatic cues and simple phobias related to trauma to be of equal weight with the commonly recognized reexperiencing symptoms of intrusive memories, nightmares, and flashbacks. Another change is that the psychological and physiological reactions are defined as

Table 1. Changes in PTSD Criteria: DSM-III-R to DSM-IV

CRITERION CATEGORY	CHANGES FROM DSM-III-R	DSM-IV
A - Stressor characteristics	"experienced" expanded	experienced, witnessed or been confronted with
	"outside the range of usual "human experience" replaced	involved actual or threatened death or serious injury or a threat to the physical integrity of or others
	"markedly distressing to almost anyone" replaced	the person's response involved intense fear, helplessness or horror. Note: In children, this may be expressed instead by disorganized or agitated behavior
B - Reexperiencing /intrusive	B (1) retained, but expanded	recollections of the event, including images, thoughts, or perceptions
	B (2) retained, but expanded	Note: In children, there may be frightening dreams without recognizable content
	B (3) retained, but expanded	(in young children, trauma-specific re-enactment may occur)
	B (4) "exposure to events" changed	exposure to internal or external cues
	B (4) "including anniversaries of tlie trauma" deleted	
	B (5) added (formerly D (6)	physiologic reactivity upon exposure to internal or external cues that synbolize or resemble an aspect of the traumatic event
C - Avoidance and numbing	C (2) retained, but expanded	efforts to avoid activities, situations, or play that arouse recollections of the trauma
D - Hyperarousal	D (6) deleted and moved to Criterion B (5)	- See B criteria -

occurring in response to either internal or external cues, whereas the prior definition stipulated that the symptoms occur in response to events symbolizing the trauma. These changes expand and elevate the importance of the intrusive/reexperiencing symptoms. Also, the addition of the qualifiers "internal" and "external" carries important implications for recognizing intrusive symptoms. "Internal" cues are inherently subjective; although this allows the clinician to identify as intrusive symptoms reactions to cues such as pain or other somatic sensations, it also requires that the person experiencing the symptoms is able to recognize the relationship of these cues to past trauma and to convey this clearly to the clinician. The evaluating clinician may now judge that a person meets criterion B, for example, when the patient experiences nausea when confronted with an odor reminiscent of the stale tobacco smell on one who abused her, or perhaps reacts with intense psychological distress while experiencing a sensation of abdominal pain similar to that experienced during sexual abuse.

The most significant DSM-IV change in the "avoidance and numbing" criterion (C) is that a person must have both avoidance and numbing symptoms to meet the diagnosis. A total of at least three of the seven symptoms must still be present, and the C2 symptom has been expanded to include avoidance of play in addition to activities or situations that arouse traumatic recollections. This change and the expanded definition of the reexperiencing symptom, B3, to include trauma-specific reenactment in young children demonstrate an increased understanding or the various behavioral effects of trauma on children, while enhancing the ability of clinicians to identify trauma-related behaviors in these patients.

In DSM-IV the number of "hyperarousal" symptoms (criterion D) has been reduced from six to five, while the minimum number of symptoms needed to meet this criterion remains at two. The symptom of physiological reactivity when exposed to reminders of trauma is now included in the B criterion (see above), as it is thought to be more consistent with the characteristics of reexperiencing phenomena. This change would seem to result in greater difficulty in establishing the hyperarousal criterion. However, the change made in DSM-III-R, where the prior DSM-III symptom of "hyperalertness or exaggerated startle response" became two separate items, was retained in DSM-IV. These two symptoms, along with the other three hyperarousal symptoms involving poor sleep, irritability, and trouble concentrating, are commonly present in persons who are actively experiencing the intrusive symptoms of criteria B. It is unlikely that any individual who meets criteria for the first three categories of PTSD symptoms would not easily qualify for this one.

As in DSM-III-R, the DSM-IV specifies that the duration of the symptoms in B, C and D must be at least one month. But the definition now includes acute (less than three months) and chronic (three months or more) subcategories. In addition, a new trauma-based disorder labeled acute stress disorder (ASD), has been added. Although the symptoms of this reaction are not exactly the same as PTSD, the illness is approximately equivalent to that of acute PTSD, except that it occurs within the first month following an extreme stressor and lasts anywhere from 48 hours to 28 days. Formal recognition of this illness raises implications regarding early treatment of traumatic stress symptoms.

ASD, as defined in DSM-IV, specifies that at least three dissociative features from a list of five must be present to meet the B criterion (see Table 2). It is well known that dissociative symptoms are common in the first few hours and days following a trauma, and is also documented that the magnitude of the acute dissociative response predicts outcome in PTSD (Holen, 1987). Some authors have agreed that the dissociative features of PTSD are of such import that treatment of these symptoms, e.g. psychogenic amnesia and flashbacks, is of paramount importance and may govern treatment at certain stages of the illness (Davidson, 1991). Recognition of ASD in a patient who has suffered a trauma, and early intervention in treating the dissociative symptoms, may have important implications for reducing the possibility of the development of PTSD.

Table 2. Dissociative symptoms of Acute Stress Disorder (Criterion B)

(1) a subjective sense of numbing, detachment, or absence of emotional responsiveness

(2) a reduction in awareness oh his or her surroundings (e.g., "being in a daze")

(3) derealization

(4) depersonalization

(5) dissociative amnesia (i.e., inability to recall an important aspect of the trauma)

Various measures which have been helpful with individuals include the use of potent benzodiazepines such as lorazepam and clonazepam, abreactive and cognitive psychotherapies, and the use of hypnotic techniques in the context of therapy. Group therapy has also been found to be useful.

Although the changes in DSM-IV do not suggest that the treatment of PTSD should undergo significant change, they do make it easier for clinicians to identify the illness when it exists. The addition of the ASD diagnosis also makes it more likely that the clinician will recognize the early psychiatric manifestations of acute trauma as an identifiable illness in the spectrum of trauma-related disease and treat it accordingly.

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CLINICAL TRAINING PROGRAM POST TRAUMATIC STRESS DISORDER

The Clinical Laboratory and Education Division for the National Center for Post Traumatic Stress Disorder at the Palo Alto CA VAMC, in collaboration with the Long Beach CA Regional Medical Education Center (RMEC) offers an on-site clinical training program in the treatment of Post Traumatic Stress. The training program is approved for category 1 continuing medical education credit.

Psychiatrists, psychologists, social workers, nurses, readjustment counselors, clinical nurse specialists, occupational and recreational therapists combine to provide a comprehensive treatment program and an education experience for the mental health professional seeking to expand his or her understanding of psychic trauma and its treatment. The Clinical Training Program offers a broad range of educational activities including

- Lectures
- Clinical research observation
- Supervised clinical activities
- Use of multimedia materials
- Group discussions facilitated by staff

Training programs are scheduled for a minimum of one week, though longer programs are available if the applicant can justify an extended stay. Programs are scheduled ten time per year, generally on the third week of the month.

At present time, funding for attendance is not available from the National Center. There is no fee for the training program itself, but participants are responsible for providing their own transportation, lodging, and meals. Interested applicants are encouraged to explore funding options through their local medical centers or RMEC. For further information, please call FTS 700-463-2673 or commercial number 415-493-5000, extension 2673.

SECOND WORLD CONFERENCE OF THE INTERNATIONAL SOCIETY FOR TRAUMATIC STRESS STUDIES

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